The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to kingcounty.gov/benefits. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 206-684-1556 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	This plan has no deductible.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.vsp.com or call 800-877-7195 for a list of network providers.	This plan uses a provider network. You pay less if you use a provider in the network. You will pay more if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose for covered services without a plan referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered.	Not covered.	None
	Specialist visit			
	Preventive care/screening/ immunization			
If you have a test	Diagnostic test (x-ray, blood work)	Not covered.	Not covered.	None
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at kingcounty.gov/benefits	Generic drugs	Not covered.	Not covered.	None
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered.	Not covered.	None
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	Not covered.	Not covered.	None
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered.	Not covered.	None
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered.	Not covered.	None
	Inpatient services			
If you are pregnant	Office visits	Not covered.	Not covered.	None
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Not covered.	Not covered.	None
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice services			
If you need dental or eye care	Eye exam	$10 copay /12 months (copay applied to exam and/or glasses)	$10 copay /12 months (copay applied to exam and/or glasses). Any amount in excess of the $50 allowance	This summarizes the VSP vision care benefit. Other limits may apply.
	Glasses	$10 copay /12 months (copay applied to exam and/or glasses, plus frame cost overage, if any) Any amount in excess of the $130 frame allowance	$10 copay /12 months (copay applied to exam and/or glasses, plus frame cost overage, if any). Any amount in excess of the following allowances: $50 - single-vision lenses $75 - lined bifocal lenses $100 - lined trifocal lenses $125 - lenticular lenses $70 - frame	
	Contact Lens Exam (fitting and evaluation)	Covered in full after $60 max copay	Any amount in excess of the $105 allowance	
	Contact Lenses	Any amount in excess of the $130 allowance		
	Dental check-up	Not covered.	Not covered.	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Routine eye care (Adult)

Your Rights to Continue Coverage: The following agency can help if you want to continue your coverage after it ends: Department of Health and Human Services, Center for Consumer Information & Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms. Other coverage options may also be available, including buying individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Vision Services Plan at 1-800-877-7195 or visit www.vsp.com

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Having a Baby
(Nine months of in-network prenatal care and a hospital delivery.)

- **The plan's overall deductible** N/A
- **Specialist coinsurance** N/A
- **Hospital (facility) coinsurance** N/A
- **Other coinsurance** N/A

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$N/A**

In this example, the patient would pay:
This condition is not covered, so patient pays 100%.

Managing Type 2 Diabetes
(One year of routine in-network care for a well-controlled condition.)

- **The plan's overall deductible** N/A
- **Specialist coinsurance** N/A
- **Hospital (facility) coinsurance** N/A
- **Other coinsurance** N/A

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$N/A**

In this example, the patient would pay:
This condition is not covered, so patient pays 100%.

Simple Fracture
(One in-network emergency room visit and follow up care.)

- **The plan's overall deductible** N/A
- **Specialist coinsurance** N/A
- **Hospital (facility) coinsurance** N/A
- **Other coinsurance** N/A

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$N/A**

In this example, the patient would pay:
This condition is not covered, so patient pays 100%.

Note: These numbers assume the patient has **not** participated in the Healthy Incentives wellness program and has the **Bronze** out-of-pocket medical expense level. For more information about Healthy Incentives, please go to kingcounty.gov/healthy-incentives.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.